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**Doctor? Who? Nurses, patient's best interests and treatment withdrawal.**

When no doctor is available, should nurses withdraw treatment from patients?

At times where a decision has been made to stop futile treatment of critically ill patients on an intensive care unit (ICU) – what is termed *withdrawal of treatment* in the UK - yet no doctor is available to perform the actions of withdrawal, such as turning off machines and removing intravenous infusions, nurses may be called upon to perform these key tasks. I recently published on the legal and professional position of English and Welsh nurses in this situation (Birchley, 2012), and suggested that nurses should construct moral justifications for such actions. In this paper I argue that any such justification must answer two major questions. One is to ask if it can be in patients' best interests for nurses to be the key actors in withdrawal of life sustaining treatment. The other is to ask if there is any reason that the nursing profession should not undertake such tasks if this is so. Both these questions require the resolution of weighty moral and philosophical issues. Thus, while offering a serious attempt to provide moral justifications for nurses undertaking withdrawal, this paper also invites debate over both the aim of task division between nurses and doctors, as well as how we might decide what is in the best interests of patients.

Drawing on prudential value theory and Doyal and Gough's (1991a) theory of need, I suggest best interests may be understood as the fulfilment of the basic human needs of health and autonomy. I offer two justifications for nurses undertaking withdrawal. The first suggests that autonomous needs may be fulfilled by a timely death, which, by allowing the nearness of family and religious representatives, allows the patient to flourish at the end of life. The second justification suggests staff on ICU have responsibilities to their patients as a community, which may require that the needs of

patients are prioritised in order to meet the most urgent needs first. In such an environment a co-operative approach to task allocation, that allows those with appropriate skills to undertake tasks to which those skills are matched, will ensure that need fulfilment is maximised. It is therefore acceptable for nurses to withdraw treatment when the intensive care unit is busy and no doctor is available.

This paper is about the key tasks involved in withdrawal, rather than the decision making process that precedes such tasks. In order to describe these key acts of withdrawal of treatment, I shall hereafter use the formulation *nurse actioned withdrawal* (NAW). Before considering the issue in more detail, I should first like to clarify some of the circumstances in which NAW takes place.

### **Case study: Circumstances where NAW takes place**

N was critically ill elder with no hope of recovery, and N's family had agreed with the healthcare team that treatment no longer served her interests. Dates for withdrawal of ventilatory and cardiovascular support were twice agreed between N's family and her consultant. On each day the family assembled and said their goodbyes, but unplanned emergency admissions increased workplace demands to such an extent that no doctor was available to turn off ventilation and remove life sustaining infusions, and the planned withdrawal did not take place, visibly adding to the family's stress. When a third date was agreed but it became obvious that, for the same reasons, withdrawal would not take place again, the bedside nurse suggested to N's family that she might be able to undertake withdrawal if this was acceptable to them. With their assent, and having sought the agreement of the consultant and nurse in charge, the bedside nurse stopped N's ventilator and infusions and N subsequently died.

### **Review of the legal position of NAW**

In a recent paper (Birchley, 2012) I discussed the legal and professional implications of nurses in England and Wales performing NAW. This topic is important because withdrawal of treatment is circumstantially similar to killing, and careful legal argument has been constructed to avoid criminalising those who undertake it. Although nurses had been largely forgotten in these legal arguments, which have been tailored to Doctors, nurses potentially derive some legal protection when withdrawing treatment on doctors' orders due to English common law recognition that nurses may act as doctors' surrogates.

This legal position can be understood in a number of ways: It recognises that the reality of much healthcare practice involves teams of doctors and nurses sharing the burden of work between them in ways that it would be impractical to demarcate. Within such teams the *de facto* position of nursing is the professional subordinate to medicine; no matter how skilled the participants, no matter how democratic the process, a doctor will be in charge and own the key decisions. While potentially protective, this legal position could be perceived as devaluing the role of nurses, characterising their activities as servile to the will of doctors. Indeed the legal position seems to clash with the more aspirational language of the Nursing and Midwifery council's professional code, with their view of collegiate professional teamworking creating a strong disjuncture with the legal position, opening the door to nurses who are legally exonerated facing professional censure.

In the face of this confusion and misrepresentation there are a number of reasons nurses who undertake NAW should find moral arguments for their actions. Firstly, a rationally argued moral standpoint will provide nurses the firm philosophical ground from which to agitate for changes in both the law and professional standards. Furthermore, professional regulators have no professed desire to punish nurses for properly conducted nursing, and moral argument may offer a defence for a nurse called upon to justify their activities by the Nursing and Midwifery Council. Finally, although common law is untested on this point, any weaknesses of the legal argument may be bulwarked by ethical reasoning because, despite the separation of law and morality in a system of positive law, judges will recourse to ethical arguments when the law reaches its limits (Waldron, 2009; Huxtable, 2007).

### **Should nurses undertake NAW?**

Any justification of NAW must answer two questions, both of which have repercussions upon wider nursing and healthcare practice. The first is to ask if NAW can be in patients' best interests. As the measurement of best interests raises questions of considerable complexity in itself, I shall consider this in a moment. The second, smaller, question is to ask, if NAW *is* in the best interests of patients, is there any reason nurses as a profession ought not to do it? It is to this question I shall turn.

### **Why not nurses?**

Arguments suggesting nurses should not undertake NAW suggest something distinctive about the role of a nurse that prohibits her from being involved in the withdrawal process.<sup>1</sup> Because any examination of nursing practice reveals many complex and highly technical tasks undertaken by nurses, arguments that nurses are too unskilled to undertake technical tasks are not worthy of lengthy response. However, a similar argument worth considering suggests there is something within the essence of nursing that is anathema to NAW. Such a viewpoint is reinforced by phrases such as “*nursing care only*” that are frequently used to describe the status of patients for whom active medical treatment is no longer being pursued, implying a clear demarcation of the duties of the nurse and the doctor. At the heart of such arguments are questions of the identity and status of nursing. For instance, considering potential nurse involvement in euthanasia, McCabe (2007) suggests that the basic values of nursing are to care for and foster life and as such are incompatible with actions that precipitate death, even when healing and life are not possible. But, given that withdrawal is meant to alleviate futile suffering, where there is no hope of healing or recovery, it is difficult to use such arguments against NAW, and indeed, McCabe is careful not to direct her criticisms at withdrawal of treatment, as it might facilitate a good death, which she argues is also a function of healing.

A different objection is that we should distinguish nursing activities from those of doctors in order to preserve the interests of the nurse. Such a strategy would, for instance, not prevent a bedside nurse from emphasising the urgency of enacting the withdrawal upon medical colleagues, while still considering the task incumbent upon that profession and thus not exposing the nurse to accusations that she had overstepped legal or professional boundaries by undertaking NAW. Yet arguments that displace patients from their central position in nursing activities, perhaps to serve bureaucratic or legal expedience, seem morally problematic. Consider the position espoused by Pohlman (1990), who advises nurses to tolerate patient's pain rather than expose themselves to legal action by administering painkillers that may inadvertently hasten a patient's death. Such a position falls far short of a satisfactory response to a real dilemma.<sup>2</sup> While discouraging nurses from exposing themselves to legal censure

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<sup>1</sup> An argument not examined here is that, because death is so important, and “killing” so abhorrent, it is socially important that only a small, trusted elite within society should be allowed to conduct withdrawal, and therefore it is a satisfactory if this trusted elite is limited to doctors. I have no space to pursue this line of thinking, but acknowledge, while by no means an insurmountable argument, it may represent a rich vein of inquiry.

<sup>2</sup> Although note that my discussion of the legal aspects of NAW may clarify the law in this situation as well. See: Birchley (2012).

is morally defensible, surely a full response would visit the legal and professional root of such dilemmas and actively work toward solutions rather than tolerating a status quo that results in human suffering.

Ultimately the reasons nurses do some things and not others is obscure, and probably sociological, rather than moral, in origin. Chiarella (2002) argues plausibly that it is founded upon the technical status of tasks, professional protectionism and nurses' position as ancillary to doctors. The hugely varied nature of what nurses actually do seems to reinforce this position; for instance nurses undertake high-level executive functions in healthcare organisations (Perra, 2001), cover medical rosters in primary care (Horrocks et al., 2002) as well as delivering a huge variety of face to face care to patients. If arguments against NAW are sociological, rather than moral, then I suggest there is no clear barrier to NAW provided we address any latent professional or legal risks.

### **Needs and the best interests of patients**

Having offered an answer to our smaller question, it now falls to me to answer the more complex question of how NAW serves patients' best interests. In the case study, I suggest NAW is attempting to do this. Yet although frequently employed as an explanation in itself, patients' best interests are neither transparent nor provable, leading some commentators (Lyons, 2010; Harrington, 2003) to identify the *best interest* standard as a rhetorical device. Others have criticised it as epistemologically unprovable, as well as incomprehensible given the multiplicity of possible outcomes to any given situation (Baines, 2008). For this reason I believe a justification of NAW on the basis of best interests must go further and explain *how* it serves them. In competent patients this is relatively simple if we agree the widely accepted formula that patients' autonomous wishes are the best possible expressions of their interests, provided these wishes are both fully informed and considered (Beauchamp and Childress, 1994a; Harris, 1995). However, for many patients, the professional identity of the person taking key actions in withdrawal will not be the subject of strong preference provided that person is sensitive and competent. In such an ambivalent situation we require a more developed explanation. More pressingly we must also consider that prior to withdrawal many patients are not competent to state their wishes on this matter due to critical illness, and it is these patients in particular who form a difficult subgroup when it comes to determination of their interests in general. Absent the patient's own opinions, we try to determine what a detached observer would agree

was in the patient's best interests. But what of the patients prior or assumed opinions? Although embraced by the some legal systems as a method for navigating around this problem, I suggest now that using proxy judgements is not entirely satisfactory.

### **The problem with proxy judgement**

I do not dispute the very powerful argument that, provided I am both in possession of, and capable of processing, all essential information pertaining to my interests, It is I who should determine where my *best* interests lie, based on my own understanding of the world and my place within it. Such an understanding is satisfactory because what I determine is best for me may not be what somebody else determines is best for them despite an outwardly identical situation; deciding my interests is a matter for my subjective opinion. Thus two patients, both faced with the same terminal illness, when offered treatment that is arduous but may extend their life by a few months, might justifiably choose opposite options based upon their subjective understanding of their interests. Such an argument is a convincing basis for rejecting paternalism in healthcare and recognising that the (informed) patient knows best, and is relatively uncontroversial. Yet holding that what is best for patients is based on their subjective preference creates problems when a patient is unable to express their interests because of critical illness. Although this is answered in UK and US law by using proxy judgement, this risks substituting the subjective opinion of another for that of the patient. Such arguments are not new (Harris, 2003; Wrigley, 2007) and I do not wish to waste too many words remaking them, but it is worth reviewing them briefly.

In proxy judgements a third party, using their knowledge of the patient, makes a decision on behalf of the patient. There are two methods of proxy judgement and both are problematic. In a substituted judgement a third party makes a proxy decision on the basis of what a rational person would want in such a situation. This is unsatisfactory because the proxy decision maker's idea of a reasonable decision may not be the patient's. Not only is the notion of what is *reasonable* unclear<sup>3</sup> but the very nature of patient autonomy is that it empowers a patient to act *unreasonably* if they so wish.<sup>4</sup> In a surrogate judgement a third party surmises the patient's decision by using

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<sup>3</sup> For instance, following the tradition of Hobbes we might see reason as self interest, whereas to followers of John Stuart Mill it might represent an acceptance of pluralism.

<sup>4</sup> One could of course argue that incompetent patients forfeit the right to have a say in their treatment, for instance because autonomous decision making is a right to be claimed. This seems to treat human beings unequally dependening on their competence and I therefore do not consider it here.

the antecedent decisions and wishes of the patient. But while the opinions of a close relative may give a reasonable guess of the patient's wishes, we should be careful to note that relatives often make incorrect guesses of their loved ones wishes – a systematic review of the accuracy of surrogate judgements suggested relatives wrongly guessed their loved one's wishes in a third of cases (Shalowitz et al., 2006). This is not surprising because, while the known opinions of the patient may be considered by the surrogate, the patient might not have discussed the nuances of their current situation; indeed, given the effect that our actual experiences have on our opinions and the often unprecedented nature of critical illness in a patient's life, it is likely that patients themselves will have little prior idea of their response in such circumstances. The surrogate is therefore left to guess the patient's likely decision, and has little option but to inform this guesswork with their own subjective opinion. Clearly simple substitution of one subjective opinion for another is a corruption of the principle of autonomy that surrogate decision making seeks to protect. I suggest we need to take a different tack and turn away from flawed attempts to reconstruct the complex and highly subjective opinions of individual autonomy - although a more simplistic notion of autonomy will ultimately be retained. Instead we should devise a more objective method of determining best interests<sup>5</sup>. I shall argue now that such a method may offer a valuable line of inquiry, but that we can never entirely escape some notion of autonomy.

### **Using need to inform objective best interests**

DeGrazia (1995) suggests that determinations of best interests often overlook the potential of prudential value theory, the study of what makes up an individual's ultimate (nonmoral) wellbeing. Within this area of philosophical theory, objective list accounts suggest we may be able to capture wellbeing within an objective list of states of affairs that are independent of both pleasure and desire. An objective list is attractive as the unconscious, terminally ill patient has no current experiences or complex desires and no hope of recovery to provide them with future experiences on which to base their future welfare (Crisp, 2008). Yet, while objective list approaches may offer us a way to quantify best interests (and indeed have been employed lately

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<sup>5</sup> A caveat: objectivity may be attractive, but has something of an end-of-the-rainbow quality. I seek to find a workable objectivity, rather than an evasive "view from nowhere". In doing so I have not considered in any depth attempts to reach such a practical objectivity through intersubjective agreement (such as those proposed by e.g. Daniels, 1979). Inasmuch as this may support the idea that we could find an objective position simply by sampling the opinions of the clinical team and the patients' advocate - which is arguably the position of the Mental Capacity Act (2005) - I suggest sampling opinions from these few individuals does not approximate objectivity.



in the courts to decide the best interests of children; Birchley, 2010) the content of such lists is contentious, with proposed items, including health, autonomy and deep personal relationships, largely included on the intuitions of the thinker (DeGrazia, 1995). In considering what we might plausibly include in such a list, a more robust approach may be to seek a developed account from within the literature. One psychological account, Maslow's *Hierarchy of Human Need* (1943) contains five broad categories of human needs, arranged in a pyramid, each of which he suggests requires fulfilment before the next. While established and familiar to many, there is little evidence for needs to be organised in such a complex hierarchical form (Wahba and Bridwell, 1976), and Maslow's mixture of objective and subjective needs may be problematic for populating an objective list. Another thoroughly argued position is that of Doyal and Gough in their seminal work *A Theory of Human Need* (1991a). There are several reasons why this theory is more attractive than Maslow's. There is a cross-disciplinary background to the researchers, and Doyal's medical ethics background may help the application of this theory to specific healthcare based scenarios. The theory is explicitly founded upon an identification of objective needs, and therefore suits the creation of an objective list better than Maslow's mixture of subjective and objective needs. Finally, while Doyal and Gough identify eleven intermediate needs, they found these upon just two basic needs, and plainly the smaller the number of items within an objective list, the easier their inclusion is to defend. I acknowledge that a number of accounts of need exist and it is possible a better model exists than Doyal and Gough's. Yet I suggest Doyal and Gough's account of needs is practically indistinguishable from approaches that attempt to quantify human wellbeing within objective lists, and it is a valid and defensible source from which to draw. In doing so I am ready to advance a detailed claim: NAW can satisfy patient need, and by satisfying needs, it serves patients' interests. To proceed I shall consider the two basic needs identified by Doyal and Gough (1991b), health and autonomy, and how these may offer us a justification of NAW.

### **Is autonomy an objective need?**

It is significant that, although they name eleven intermediate needs, Doyal and Gough (1991b) consider that there are only two basic needs, and it is upon these I wish to focus: *health*, as it facilitates much of human action, and *autonomy*, because without the ability to freely choose our own aims and goals we cannot connect our reasons to our actions. I suggest it is worthy of some comment that autonomy, through

which we express our preferences, is considered an objective human need because notions of autonomy, while representing a concept that can be used objectively, also appears to demand a subjective input from the patient as well. This is important because the patient population for whom we have determined an objective list approach is needed is largely unable to provide this subjective input, and I have already suggested we must avoid proxy decision making as it risks substituting a proxy's subjective account of interests for the patient's. Only by separating the subjective and objective strands of autonomy can it feasibly inform an objective account of best interests. To do this, let us consider the nature autonomy.

While I acknowledge there are complex psychosocial elements of health, for my argument it is a more simplistic, medically modelled measure that I consider here. In this way, by objective measures such as cardiovascular stability and respiratory sufficiency, health is easy to define. Meanwhile, autonomy has a multitude of meanings; for instance autonomy has been variously proposed to be based on rights (Baggini and Fosl, 2007a), on trust (Stirrat and Gill, 2005) and on social relationships (Verkerk, 1999). Doyal and Gough (1991b) define autonomy as the way an individual facilitates action, but this seems to require more explanation. For autonomy does more than just facilitate action but governs the internal, subjective elements of personal choice that govern individual actions and responses as well. Thus I suggest autonomy has both elements that can be fulfilled objectively by providing for our needs, but also subjective elements that govern individual choices. Any account of objective best interests must begin by taking account of the relationship between these elements, in order to be sure that it only includes the objective elements (in other words the elements that can be provided externally) and is thus fit for purpose. A satisfactory account is nevertheless tricky, as the boundary between these subjective and objective elements is fuzzy. Thus my autonomy may be impinged from an objective point of view if I am constrained from choosing by imprisonment or illness, however the choice I am exercising is itself a subjective choice, governed by my free will and personal decisions. These elements of subjective and objective autonomy are not divisible, as one means nothing without the other: If I drink but do not choose to, I lack autonomy. If I choose to drink but am restrained from drinking, I have, it is true, *chosen*, but I have not facilitated the action of drinking, so also lack autonomy. Only by the choosing *and* the doing am I exhibiting autonomy.

Given this subjective aspect, how is it possible that autonomy is an objective need? Doyal and Gough (1991b) suggest it is because autonomy gives value to human

existence, so that while autonomy flows from health, health only has a value if we can exercise this autonomy, this freedom to choose and do. Our population of patients, deeply sedated and critically ill, clearly lack the ability to *do* - their autonomy is diminished - but what of the freedom to choose? If in some way the manner of their death can imply a choice, then NAW can indeed be justified by appeals to autonomy. I now argue that, at least within this narrow context, these expressions of autonomy can be defined as those that add value to human life, and death.

### **Autonomy, death and Flourishing**

I have concluded above that autonomy can be understood as a basic, objective need, no less vital than health itself to our humanity. Autonomy facilitates action, but I have proposed that this action is deeply bound up with the choice it expresses. In our deeply sedated, critically ill patients, who have no future but to die, action is impossible and choice is constrained severely. For this reason, I suggest autonomy at the end of life relates particularly to self expression, and in NAW by the choice of the circumstances of one's death. Self expression at the time of death contains significant unquantifiable elements; dying must encompass more than the facts surrounding a death, but also more qualitative elements such as *how* we die. Virtue ethicists have adopted the Aristotelian term that encompasses the goals of a fulfilled life, *eudaimonia* (Baggini and Fosl, 2007b), and I suggest that we can use this term, usually translated as *flourishing*, as it seems to encompass the significant but immeasurable qualitative variables that we must respect when we consider human existence. I suggest that it is possible to respond to patients basic, autonomous needs at the end of life by allowing flourishing. The timing of death is a key circumstance and a self expressive concern, at least where it is or was material to the patient or their family. This will very possibly be the case, as families are usually keen to be with a relative when they die and timing will also affect the satisfaction of religious observations at and around the time of death (Fridh et al., 2007), so it seems defensible to claim that legitimate autonomous needs are impinged if timing of death is haphazard.

Timing of death may become haphazard if taking the key actions in withdrawal of treatment is dependent upon the availability of a doctor. In most cases withdrawal of treatment takes place in ICU, where there may be very high levels of patient demand and relatively fewer doctors available compared to nurses due to the numbers rostered on any particular shift. Given the importance of meeting autonomous needs that will

be affected by the timing of death, such as presence of relatives or religious representatives, I suggest that NAW may be justified on the basis of upholding patients' best interests, specifically their need for autonomy.

### **A further justification of NAW**

I have argued that NAW may be justified on the basis of autonomy. I wish to consider if there is a second justification for NAW. One argument, that to wait for a doctor would increase the burden of suffering upon the patient, seems to fail, as we must believe suffering is being minimised through the judicious use of medication in order to countenance waiting for religious and familial concerns to be satisfied. I would like instead to consider if we can reframe the way we approach patient need, based upon a communitarian standpoint and accounting for the critical needs of the patients on ICU as a whole. In the following section I argue that, as healthcare professionals have different sets of skills, there is an obligation for them to take a communitarian approach to task allocation, and such an approach may entail nurses taking on roles, such as NAW, for which they are appropriately skilled, in order that others with different skill sets may fulfil the urgent needs of other patients. Such an argument presents some necessary limits to autonomy in healthcare. I also suggest it presents a strong argument for allowing NAW.

### **A place for Communitarianism in ICU**

Following Doyal and Gough (1991a), I have agreed that the basic needs of persons consist of health and autonomy, and suggested that the need to flourish at the end of life may be served by the timeliness of death, facilitated by NAW. In this section, I suggest a second justification of NAW based on a communitarian approach to fulfilling health needs on the ICU. I argue that need fulfilment extends to the overall needs of the patients on the ICU. Naturally this may bring the needs of autonomy and health into conflict, and in such cases, we must prioritise urgent health needs over autonomy, meaning, in critical situations, that individual autonomy must temporarily yield to the urgent health needs of others as long as this critical situation lasts. This impacts upon withdrawal because, as I have proposed circumstances of death are a function of autonomy, and timing of death may be a key circumstance, timely withdrawal for one patient is an autonomous need that may be over-ridden by the more urgent health needs of others. One practical method of both ameliorating the

effects of this and maximising the fulfilment of need (and thus the best interests of patients) is by healthcare practitioners disregarding a demarcation of tasks based on tribalistic interprofessional boundaries and focusing their skills upon the tasks to which they are most suited. Where critical health needs exist that require the special skills of doctors, it is justifiable that appropriately skilled nurses undertake NAW as such actions enable maximisation of need fulfilment.

Displacing, even temporarily, individual autonomy from its primary place in healthcare ethics is controversial and requires at least an explanation, if not a fundamental reappraisal of the healthcare environment.<sup>6</sup> To commence this I shall begin by introducing key communitarian ideas, before applying their critique to the status of the communal and the personal in contemporary healthcare ethics.

### **MacIntyre, Communitarianism and Autonomy**

In a key work of communitarian ethics,<sup>7</sup> MacIntyre argues we must re-engage with Aristotelian thinking (MacIntyre, 2007). Of particular importance is the suggestion, bound to the concept of *telos* (often translated as 'purpose in life'), that a good life is a journey that travels through the correct places rather than to a point of personal enlightenment, a journey that encompasses both the person and the society to which they belong. MacIntyre (2007) criticises the dominant ethical schema for elevating personal and private morality above the broader society in which humans function (Bell, 2009). Such schemas are nowhere more dominant within healthcare, where ethics is dominated by the four principles approach, wherein autonomy has gained an importance above the other principles that govern it (Gillon, 2003) and upholding autonomy is the paramount consideration. I shall term this the *pro-autonomy* viewpoint. If, as its adherents accept (Beauchamp and Childress, 1994a; Gillon, 2003), the principle of autonomy primarily concerns itself with individual rights (not

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<sup>6</sup> Although arguable, I suggest there is widespread evidence for the primacy of autonomy within healthcare. In a moment I suggest that commentators such as Gillon have explicitly argued that autonomy is the most important ethical principle within healthcare. Similarly, sociological examinations of healthcare note the widespread institutional acceptance of autonomy is the 'success story' of medical ethics (Zussman, 1997). Moreover, the UK experience of the use of patient choice as a tool for raising healthcare quality has been the mantra of successive governments that amounts to a consensus among the political class. While it is sensible to maintain that there are defacto limits to autonomy (and my argument could be considered to defend such a position) I would also suggest that limits to autonomy due to resource scarcity and have largely been ignored or at least (in the case of the UK's National Institute Clinical Excellence) widely disparaged in favour more politically expedient approaches to public policy. Similarly the US legal system explicitly places autonomy at the heart of controversial healthcare decisions about patients, see e.g. Griffith (1991).

<sup>7</sup> "After Virtue" has been described by others as communitarian, rather than by its Author, who essentially rooted it within Virtue Ethics.

only the right to refuse treatment, but also with rights to direct and control one's treatment), it is appropriate to ask if such an approach will maximise the meeting of need within the confines of an ICU. I suggest that the elevation of autonomy ignores the communal nature of healthcare, because practitioners are practically, morally (and legally) responsible for the needs of *all* of their patients. In this environment, effective prioritisation is needed, and an urgent need must yield to a less urgent need. While this may be a defacto situation in healthcare due to limitations on resources, my suggestion is that it can be explained using something other than an appeal to social justice or a rejection of ethics for expediency, by appealing to the nature of need itself. I suggest a critical health need may at times be more urgent than an autonomous need, and therefore, sometimes autonomy must yield to the satisfaction of the health needs of others. This notwithstanding autonomy is important and requires a robust defence. We can do this by re-examining its value within the special context of healthcare environments.

### **The special nature of the healthcare environment**

A *pro-autonomy* approach, places the autonomous individual at the *centre* of any schema and looks for justifications to flow from them (Gillon, 2004). This is because such an approach tends to rightly concern itself with the legal and political rights of citizens in mainstream society. But the healthcare environment differs considerably from normal day to day participation in society; patients are often weak and unable to participate fully or at all in decisions, and these decisions encompass a complex body of knowledge they may not fully appreciate. The aims of healthcare are similarly unusual, as they are both nurturing and, importantly, impossible to achieve without a co-operation between the patient (and often their family) and the healthcare team. Given this, highly unusual, co-operative environment, we must ask if a *pro-autonomy* approach is always appropriate as a justification of the activities of healthcare professionals. I suggest that a wholesale importation of the *pro-autonomy* approach to autonomy is as a result of a misconception of the purposes of healthcare as an individualistic and conflict driven arena, yet healthcare is anything but individualistic and involves nurses and doctors of varying skill levels working in close proximity to one another toward a common goal; the meeting of the needs of their patients. In order to meet these needs, it is sometimes necessary to prioritise the needs of different patients depending on their urgency, and this will entail setting aside the needs of one

patient in favour of another. I suggest this is justifiable because the urgent need for health outweighs the need for autonomy.

### **Why the need for health can trump the need for autonomy**

As I discussed earlier, autonomy seems potentially problematic as an item on an objective list of needs, because it contains strong subjective elements. However it earns a place on a list of objective needs due to the value it gives to human existence, and it is this addition of value that strongly binds it to health, for without autonomy, health itself has a much reduced value. We can see from this that the ability to satisfy the patient's subjective understanding of their need *in itself* forms an important part of basic, objective, human need. However, I suggest the purely objective elements of need are more urgent because without health, autonomy can never be achieved. In satisfying the best interests of a patient population, satisfaction of critical health needs must therefore take precedence over satisfaction of needs of autonomy. Such a ranking of needs has broad acceptability among theorists; Doyal and Gough speak of need being satisfied either *critically* or *optimally* (1994a), while Wiggins and Dermen (1987) use identical concepts to separate *instrumental* from *categorical* needs. Nevertheless, as the satisfaction of autonomy contains vital protection for the individual, it remains valuable. In a moment I must clarify how we should express this value in the healthcare environment. But first I must offer arguments against the strength of my claim that urgent health needs might trump autonomy.

### **Why this argument does not defeat the claim that NAW can be in patient's best interests**

The claim that vital health needs can override autonomous needs when they compete requires some finessing, as it potentially defeats the claim that NAW is in the patient's best interests. One defeating argument says that if urgent health needs trump autonomous needs, then when a patient wants their treatment withdrawn we should override the patients' wishes at the time of death because they compete with a more urgent health need; that of keeping them alive as long as we might.

A second argument claims that, if health trumps autonomy, then I am automatically better off if I am locked in a prison cell all my life, but kept in perfect health.

I have two objections to these arguments. In the first instance I suggest such actions as keeping a person alive as long as possible would not really serve the needs of health if health was unattainable; however, this argument might be effective against

patient requests for euthanasia in healthy individuals, or where their health could be maintained for some time; importantly it does seem to allow that we might be better off healthy and in a prison cell. To counter this, my second objection is that such arguments misunderstand the nature of need as I have proposed it. To preserve health in a non-urgent context at the perpetual cost of autonomy does not recognise the intimate binding of both health and autonomy that we must accept if they are both basic needs. Health is a critical need because only with health is autonomy possible, yet to pursue health in order to purposely override autonomy does not recognise the fundamental importance of autonomy to being human. There is of course a time critical element where health must be the priority as it is an urgent need which, if not satisfied, will curtail autonomy irrevocably. Yet, in a non-urgent clinical situation, it is ultimately for the patient to define their non-critical health needs.

### **The nature of Autonomy in a healthcare environment**

I suggested a moment ago that autonomy may have a particular value in the healthcare environment. It is important to clarify this because of the potentially dangerous and radical assault on the individual that overriding autonomous needs can constitute, as satisfying autonomy can offer vital protections against tyranny. It is this repudiation of autonomy which has been most central to criticism of communitarianism; for, it is argued, without satisfying autonomy the needs of the individual are liable to be crushed by greater needs of society at large (Beauchamp and Childress, 1994b) - indeed there is a long and depressing history throughout the world of individual oppression being justified on behalf of the 'common good' (Baggini and Fosl, 2007c). This is a valid criticism and when self sacrifice is demanded of individual members of society in the name of the greater good, I suggest it is not truly in the common interest if it disproportionately affects one section of society.<sup>8</sup> But to a great extent this is beside the point; autonomy in healthcare seems to be far removed from the crushing wheels of society, and it has long been problematic to apply principles of autonomy and self direction to one of the most dependent population of all, the sick. For example, legal cases where very sick people have refused treatment have questioned the ability of the ill to make balanced judgements (Brazier and Bridge, 1996), and these continue to excite considerable legal and philosophical debate (MacLean, 2008).

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<sup>8</sup> I suggest this may be a central difference between utilitarianism and communitarianism, as the atomistic nature of utilitarian benefits imply the legitimate sacrifice of the few for the many whereas communitarianism suggests a communal benefit that could measure the detrimental societal effect of such "population sacrifice". It is beyond the scope of this paper to argue such a point more thoroughly.



Further, the concept of autonomy seems to have become far removed from the theories of its founding father JS Mill, whose political background concerned him with the right of an individual to live life without the violent oppression of the majority (Wilson, 2007). Unfortunately the concept of autonomy has become elevated to such an extent that even the unbidden plucking of an eyelash or the taking of a harmless mouth swab (Archard, 2008) are seen by contemporary ethicists as major assaults upon individual autonomy. Yet if we take the concept of autonomy back to its Millian roots, I suggest there is no reason that it cannot be accommodated within a communitarian framework. As Beauchamp and Childress (1994b) concede, it is very much a false dichotomy to suggest that the needs of the community and the needs of the individual are opposed to so great a degree that we must always choose one or the other. In his communitarian analysis of East Asian societies, Bell (2006) argues that those cultures do not assign scant value individual rights, but rather give them less priority than other communal concerns in cases where the two conflict. Applying such reasoning to ICU, it is entirely legitimate that we support autonomous needs of individuals while there is a clear and unconflicted benefit for the population as a whole that we do so, because autonomy is a basic human need. However, where the autonomous needs of one individual conflict with the urgent health needs of another, these health needs must be satisfied first.

### **NAW maximises need fulfilment in ICU**

To justify NAW, I have already made an argument that the circumstances of death are an autonomous need because they are self expressive and contribute to individual flourishing. As I have described above, this autonomous need may be set aside if staff are busy meeting specific urgent health needs of other patients. If this is the case NAW seems desirable as withdrawal of treatment requires no specifically medical skills, and the greater number of nurses than doctors on duty means that a nurse is more likely than a doctor to be available. Healthcare is a co-operative environment where healthcare professionals work together to meet the needs of patients. Nurses and doctors, in particular, work closely together, and although their skills overlap, there is both demarcation of labour and a subdivision of focus. Simplistically explained this division means that doctors focus upon management of particular technical health interventions within a caseload, while nurses take care of the remaining patient needs, ensuring that not only health needs but autonomous needs are met. If medical staff have particular skills, built around high intervention

therapies, by which to promote health in patients, and those skills are in short supply due to small numbers of doctors working on any shift, it makes no sense to demarcate a task to them that is well within the skill set of nurses. Ensuring the appropriate task is undertaken by the appropriate individual is not a hierarchical division between the noble and the vile, but a division based on co-operation, because only with this co-operation between one healthcare professional and another, can the common goal of meeting the needs of patients be achieved, and the common good be served. In such an environment, the allocation of one professional to a task to which they are appropriately skilled, if it allows another to undertake a task another professional cannot, is an active good as it maximises benefits to patients.

## **Conclusion**

There is now increasing recognition that needs at the time of death are hugely important to patients and their families (Steinhauser et al., 2001; Fridh et al., 2007). Historically, the pre-eminence of medical paternalism meant that this importance was set aside in the belief that death was too ugly and distressing to be witnessed by families or acknowledged by patients. Yet it is now widely accepted that outcomes in line with the patient's wishes are an acceptable yardstick of excellence, and may sometimes contradict received medical wisdom. It is this complex inter-relationship between the health needs and the autonomous needs of the patient that I have tried to bare in my discussion of need, for if we can capture something of the essence of human need, we can begin to rationalise the actions of those working to fulfil the best interests of patients in the demanding environment of the ICU. As I argue above, a model of ethics that places patient autonomy at the centre of this environment fails as an explanation. Patient autonomy is vitally important, forming a key part of what allows us to be human, but this autonomy is intimately bound to health, and is valueless without it, for the freedom to formulate action without the ability to exercise it is, to all practical extents, the same as a denial of that freedom. Healthcare professionals on the ICU have a duty to not one, but all the patients in their care, and in such an environment the vital needs of autonomy and health are sometimes thrown into competition; the fact that health is the precursor of autonomy means that in such a situation, the meeting of urgent health needs must be a priority. The varying skills of ICU professionals mean this thwarting of autonomous needs can be ameliorated if NAW takes place. The fact that healthcare is a co-operative environment based on a common aim – to satisfy the best interests of patients – also means that this overruling

of autonomous needs for the sake of the common good is less critical than in mainstream society. Despite this there must a commitment to autonomy and by bringing the skills of all practitioners to bear, rather than narrowly demarcating professional roles, we can optimise the satisfaction of both of these needs.

Upholding the best interests of patients must be the central role of the healthcare professions. The circumstances of a patient's death are a vital part of these interests and it is unacceptable that patients and their families may endure hours or days of waiting for a doctor to become available. I have concluded there are sound moral arguments for nurses to take an active role in planned withdrawal of treatment. By clearly identifying the benefits for patients, practitioners can defend their practice from narrow or bureaucratic demarcation of roles that is detrimental to practice and morally unsustainable.

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